Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS1774AGC	A. BUILDING _____ B. WING _____	C 10/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOYALTON OF LAS VEGAS	3025 E RUSSELL ROAD LAS VEGAS, NV 89120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation survey conducted at your facility on 10/29/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility is licensed as a residential facility to provide care for 105 persons, with 89 beds for elderly or disabled persons and 16 beds for persons with Alzheimer's disease, Category 2 residents. Eleven resident files were reviewed. There were 12 complaints investigated during the survey. Complaint #NV00018047- Substantiated (Tag # Y0816) Complaint #NV00018106- Substantiated (Tag # Y0896) Complaint #NV00018209- Substantiated (Tag # YO898) Complaint #NV00018180- Substantiated (Tag # Y0503) Complaint #NV00019408- Substantiated without deficiencies Complaint #NV00018643- Substantiated without deficiencies Complaint #NV00018011- Substantiated without deficiencies Complaint #NV00019694- Unsubstantiated Complaint #NV00018606- Unsubstantiated Complaint #NV00018008- Unsubstantiated Complaint #NV00017951- Unsubstantiated Complaint #NV00019344- Unsubstantiated	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 000	Continued From page 1 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	Y 000		
Y 503 SS=F	449.258(4) Employee Compliance with Written Policies NAC 449.258 4. The employees of the facility shall comply with the policies developed pursuant to this section. This ELEMENT is not met as evidenced by: Based on observation and interview the administrator failed to provide oversight and direction for the members of the staff of the facility as necessary to ensure residents receive needed services and protective supervision and the facility was in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS. Findings include: Observation of the assisted living back doors leading to the parking lot, the side door leading to the street, and the west front door revealed that the doors alarm when opened. Interview with the Administrator indicated the alarmed doors lead to either the parking lot or close to a street and were considered emergency	Y 503		

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Y 503	Continued From page 2 exits. The doors alarm to alert staff, a resident may have exited the facility to what was considered an unsafe area. When the alarm sounds, the facility policy required staff to check the doors and surrounding outside area to determine if a resident had left the facility. The Administrator confirmed there was an occurrence in late April 2008 when the doors alarmed and the staff did not check the alarmed exits to determine if a resident exited through these doors. It ws determined that no resident had left the facility. Since the occurrence the staff had been re-inserviced on the policy concerning the alarmed doors and the expected staff response. Severity: 2 Scope: 3 Complaint #NV00018180	Y 503		
Y 816	449.2732(3)(b) Protective Supervision NAC 449.2732 3. The administrator of a residential facility with a resident who requires protective services shall ensure that: (b) There is a written plan for providing protective supervision for that resident. This Regulation is not met as evidenced by: Based on observation , interview and document review, the facility failed to ensure a resident who required protective services had a written plan for providing protective supervision.	Y 816		

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Y 816	Continued From page 3 (Resident #5) Findings include: On 10/29/08 at 3:50 PM, Resident #5 was found to be confused and disorientated to place and time. The resident could not ambulate and used a wheelchair. The resident required assistance when transferring from the bed to a wheelchair. On 10/29/08 at 1:50 PM, the Resident Care Director acknowledged Resident #5 had sustained numerous falls at the facility while attempting to get out of her wheelchair. The resident was transferred to the memory care unit on 05/01/08 for closer observation. The resident' s bed was lowered and placed against a wall but the daughter objected and insisted the bed be raised. The Care Director indicated the staffing ratio on the memory care unit was one caregiver to every six residents. The Care Director acknowledged the resident had fallen three times since being transferred to the memory care unit. The Care Director confirmed the resident fell on 02/21/08, 03/29/08 and 04/20/08 prior to being transfered to the memory care unit. The patient fell on 06/10/08, 06/16/08, 07/28/08 and 09/02/08 after being transfered to the memory care unit. On 10/29/08 at 2:00 PM, the Administrator reported Resident #5 had a diagnosis that included Dementia. The resident was not using the call system and falling when getting out of bed and when transferring from a wheelchair to the bed. The resident was placed on a fall management program that included lowering the resident 's bed and placing the bed next to a wall. There were no other interventions tried. A service care plan with interventions to reduce the risk of	Y 816		

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Y 816	Continued From page 4 falls was implemented. The resident 's daughter objected to the resident 's bed being lowered and insisted the bed be raised. On 05/01/08 the resident was moved to the memory care unit for closer observation by staff. The Administrator reported the facility can not use restraints or bed rails to prevent falls at the facility. The resident was moved next to the day room and Alzheimer 's Program Directors office for closer observation. The resident was currently on hospice care. On 10/29/08 at 3:45 PM, the Alzheimer' s Care Coordinator acknowledged that no care plan for high risk falls was developed or implemented per facility policy on Resident #5. A Resident Incident Tracking form dated 02/21/08, indicated Resident #5 was observed on the bathroom floor and transported to the emergency room for treatment. A Resident Incident Tracking form dated 03/29/08, indicated Resident #5 sustained a bruised swollen eye from an unknown event. A Resident Incident Tracking form dated 04/20/08, indicated Resident #5 sustained a fall with injury and was sent to the hospital for treatment. A Resident Incident Tracking form dated 06/10/08, indicated Resident #5 sustained a skin tear and was sent to the hospital for treatment. A Resident Care Information Sheet dated 06/16/08, indicated resident #5 was found on the floor. A Progress Note dated 07/28/08, indicated Resident #5 was found on the floor. No injuries	Y 816		

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Y 816	Continued From page 5 were noted. A Progress Note dated 09/02/08, indicated Resident #5 had a fall over the weekend and sustained multiple bruises to the forehead. A Facility Fall Management Program policy dated 12/05, indicated a resident who was a high fall risk required development of a service care plan with interventions implemented to reduce higher risks of falls. Complaint # 18047 Severity: 2 Scope: 1	Y 816		
Y 896	449.2744(1)(b)(2) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (2) The date and time that the medication was administered. This Regulation is not met as evidenced by: Based on interview and document review the facility failed to maintain an accurate record of the medications administered for one of eleven residents. (Resident # 6) Findings include:	Y 896		

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Y 896	Continued From page 6 On 10/29/08 at 9:20 AM, the Administrator reported Medication Tech #1 was responsible for administering Resident #6s medication on 04/11/08. The Administrator reported Med Tech #1 was terminated from employment in 09/08 for not signing the Medication Administration Record when administering medications to residents and not signing out narcotic medication. Med Tech #1 was leaving medication at the residents bedside in violation of the facilities medication administration policies. A Medication Administration and Management form dated 06/28/06 and signed by Resident #6, indicated the resident designated the facilities employees to possess, administer and monitor her medications. A Medication Administration Record (MAR) for Resident #6 dated 04/01/08 through 04/30/08 revealed no initials documented on the MAR for 04/11/08 that indicated the 8:00 PM doses of Lithium and Seroquel medications were given to the resident. The facilities Medication Assistance policy dated 12/05, indicated medications were charted at the time of administration or assistance." Medications are not left unattended anywhere in the community." Severity: 2 Scope: 1 Complaint # 18106	Y 896		
Y 898 SS=D	449.2744(1)(b)(4) Medication / MAR NAC 449.2744	Y 898		

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Y 898	Continued From page 7 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician. This Regulation is not met as evidenced by: Based on interview and document review the facility failed to ensure that the medication given to a resident reflected the physician's order. (Resident #7) Findings include: Resident #7 was admitted on 10/24/06. Interview with the Administrator revealed that on 4/30/08 Resident #7 was given another resident's Zoloft which was not ordered for Resident #7 by the physician and was not on the Medication Administration Record (MAR). The physician was notified of the event. The Administrator indicated the medication technician was terminated for this and other occurrences. Document review of the facility occurrence report confirmed the administration of the Zoloft to Resident #7. Severity: 2 Scope: 1 Complaint #18209	Y 898		